PHOEBE RICH DERMATOLOGY
Oregon Dermatology & Research Center

Medical History Intake Form

Medical Conditions by Body System

*Please list only **conditions diagnosed by a healthcare provider**.*
All related medications, treatments, and supplements should be listed on the New Patient Medication Form.

Heart & Blood Vessels ☐ None *e.g., high blood pressure, heart disease, arrhythmias, etc.*	**Start Date** Month/Day/Year (Year required)	**End Date** Month/Day/Year (Year required)	**Taking Medication(s)?**
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes

Comments / Additional Information:

Lungs & Breathing ☐ None *e.g., asthma, COPD, sleep apnea, etc.*	**Start Date** Month/Day/Year (Year required)	**End Date** Month/Day/Year (Year required)	**Taking Medication(s)?**
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes

Comments / Additional Information:

Endocrine & Metabolic ☐ None *e.g., high or low cholesterol, diabetes, thyroid disorders, etc.*	**Start Date** Month/Day/Year (Year required)	**End Date** Month/Day/Year (Year required)	**Taking Medication(s)?**
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes

Comments / Additional Information:

Digestive System ☐ **None** *e.g., acid reflux, peptic ulcers, IBS, Crohn's disease, etc.*	**Start Date** Month/Day/Year (Year required)	**End Date** Month/Day/Year (Year required)	**Taking Medication(s)?**
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
Comments / Additional Information:			

Brain & Nervous System ☐ **None** *e.g., migraines, seizures, stroke, multiple sclerosis, etc.*	**Start Date** Month/Day/Year (Year required)	**End Date** Month/Day/Year (Year required)	**Taking Medication(s)?**
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
Comments / Additional Information:			

Psychiatric / Mental Health ☐ **None** *e.g., depression, anxiety, bipolar disorder, ADHD, etc.*	**Start Date** Month/Day/Year (Year required)	**End Date** Month/Day/Year (Year required)	**Taking Medication(s)?**
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
Comments / Additional Information:			

Bones, Joints & Muscles ☐ **None** *e.g., arthritis, osteoporosis, chronic pain, etc.*	**Start Date** Month/Day/Year (Year required)	**End Date** Month/Day/Year (Year required)	**Taking Medication(s)?**
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes

		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
Comments / Additional Information:			

Skin ☐ **None** *e.g., eczema, psoriasis, rosacea, alopecia, etc.*	**Start Date** Month/Day/Year (Year required)	**End Date** Month/Day/Year (Year required)	**Taking Medication(s)?**
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
Comments / Additional Information:			

Liver, Kidneys & Urinary Tract ☐ **None** *e.g., kidney disease, liver disease, hepatitis, recurrent UTIs, etc.*	**Start Date** Month/Day/Year (Year required)	**End Date** Month/Day/Year (Year required)	**Taking Medication(s)?**
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
Comments / Additional Information:			

Blood / Autoimmune ☐ **None** *e.g., anemia, clotting disorders, bleeding disorders, lupus, etc.*	**Start Date** Month/Day/Year (Year required)	**End Date** Month/Day/Year (Year required)	**Taking Medication(s)?**
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
Comments / Additional Information:			

Reproductive / Gynecologic ☐ **None** *e.g., PCOS, endometriosis, prostate conditions, etc.*	**Start Date** Month/Day/Year (Year required)	**End Date** Month/Day/Year (Year required)	**Taking Medication(s)?**
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
Comments / Additional Information:			

Ears, Nose & Throat ☐ **None** *e.g., chronic sinusitis, hearing loss, tinnitus, etc.*	**Start Date** Month/Day/Year (Year required)	**End Date** Month/Day/Year (Year required)	**Taking Medication(s)?**
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
Comments / Additional Information:			

Eyes ☐ **None** *e.g., glaucoma, macular degeneration, cataracts, etc.*	**Start Date** Month/Day/Year (Year required)	**End Date** Month/Day/Year (Year required)	**Taking Medication(s)?**
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
Comments / Additional Information:			

Cancer ☐ **None** *Please include all past and/or current cancer(s).*	**Start Date** Month/Day/Year (Year required)	**End Date** Month/Day/Year (Year required)	**Taking Medication(s)?**
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes

		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
Comments / Additional Information:			

Infectious Diseases ☐ **None** *e.g., tuberculosis, HIV, hepatitis, etc.*	**Start Date** Month/Day/Year (Year required)	**End Date** Month/Day/Year (Year required)	**Taking Medication(s)?**
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
		☐ Ongoing	☐ Yes
Comments / Additional Information:			

Surgeries & Hospitalizations ☐ None

*Please list any **past surgeries or hospitalizations**, as well as any **planned or upcoming procedures**.*

Event	**Reason / Location**	**Start Date** Month/Day/Year (Year required)	**End Date** Month/Day/Year (Year required)
			☐ Ongoing
			☐ Ongoing
			☐ Ongoing
			☐ Ongoing
			☐ Ongoing
Comments / Additional Information:			

Social History

Please complete all items below. Additional information is optional.

Social History Item	**Amount / Type / Frequency** (e.g., 2 cups black coffee daily)	**Start Date** Month/Day/Year (Year required)	**End Date** Month/Day/Year (Year required)
Caffeine ☐ Never used			☐ Ongoing
Alcohol ☐ Never used			☐ Ongoing
Smoking Tobacco ☐ Never used			☐ Ongoing

Smokeless Tobacco ☐ Never used			☐ Ongoing
Marijuana or Recreational Substance(s) ☐ Never used			☐ Ongoing

Comments / Additional Information:

Allergies ☐ None

*Please specify both the **allergen** and the **reaction**.*

Allergen *e.g., peanuts*	Reaction *e.g., hives and swelling*	Start Date	End Date	Taking Medication?
			☐ Ongoing	☐ Yes
			☐ Ongoing	☐ Yes
			☐ Ongoing	☐ Yes
			☐ Ongoing	☐ Yes

Comments / Additional Information:

Is there anything else you'd like our healthcare team to know?